

SEMINOLE COUNTY SPECIAL NEEDS REGISTRATION

Please check appropriate box: ☐ Temporary Eligibility (1 year or less)
☐ Permanent Eligibility

FOR EMERGENCY MANAGEMENT/HEALTH DEPARTMENT USE ONLY: Placement Code: _____ Date: _____
Station: _____ Map Page: _____
1) __ Staying Home 2) __ Regular Shelter 3) __ Special Needs Shelter: _____
4) __ To Family/Friends/Other: _____ 5) __ To Nursing Home: _____
6) __ To Hospital _____ 7) __ Needs Transportation

Last Name _____ First _____ M.I. __ Sex: F __ M __ Birthdate: _____
Street Address: _____ Apt.# _____ City _____ Zip _____ Telephone: _____
Home Type: ☐ Mobile/Manufactured (Name of Mobile Home Park): _____ Lot No. _____

☐ Single Family ☐ Apt/Condo ☐ Floor _____ Do you live alone? ☐ Y ☐ N

Emergency Contact Name for Caregiver: _____ Telephone: _____

Doctor’s Name: _____ Telephone: _____

Do you receive care in home through a State agency ☐ Community Assistance ☐ Home Health ☐ Hospice ☐
If checked, please give Name _____ Telephone: _____
Do you have a pet? ☐ Y ☐ N If yes, what type ☐ dog ☐ cat ☐ other: _____
Will you be accompanied to the shelter by a caregiver/family member ☐ Y if yes, how many? _____ ☐ N
Can you take care of yourself ☐ Y ☐ N What is your height?: _____ Weight?: _____
Do you speak English? ☐ Y ☐ N if no, what is primary language? _____
Are you deaf/hearing impaired? ☐ Y ☐ N Are you blind/visually impaired? ☐ Y ☐ N

CATEGORY A – Anyone who can walk without assistance and needs no outside professional assistance in performing activities of daily living. Anyone who can provide their own transportation, medical care and does not have life threatening problems, but would feel more comfortable in a shelter.

CATEGORY B – Individuals who require minor medical assistance in activities of daily living who are accompanied by a caregiver. Includes some individuals in wheelchairs who are able to take care of themselves without assistance. Please check all that apply.

<input type="checkbox"/> Use walker/wheelchair/cane or crutches	<input type="checkbox"/> Paralyzed: Severity & where _____
<input type="checkbox"/> Need assistance to go to toilet or lie down	<input type="checkbox"/> Colostomy or ileostomy
<input type="checkbox"/> Need help with medications	<input type="checkbox"/> Oxygen dependent
Injections __ Oral meds	<input type="checkbox"/> Cerebral palsy
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Parkinson’s	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Indwelling Catheters	<input type="checkbox"/> Stroke
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Alzheimer/dementia
<input type="checkbox"/> Cardiac Condition	<input type="checkbox"/> G-tube feeders
	<input type="checkbox"/> Other (explain) _____

CATEGORY C – Anyone who is permanently restricted to bed with a stable or unstable medical condition and requiring ongoing medical supervision. Those people who cannot perform activities of daily living on their own, and/or do not have a caregiver. Please check all that apply.

<input type="checkbox"/> Bedbound	<input type="checkbox"/> Cardiac (unstable)
<input type="checkbox"/> Respirator/Ventilator	<input type="checkbox"/> Full Term Pregnancy
<input type="checkbox"/> Seizures (if unstable, explain below)	<input type="checkbox"/> Contagious/Infectious
<input type="checkbox"/> Psychosis (if unstable, explain below)	<input type="checkbox"/> Dialysis (Frequency) _____
<input type="checkbox"/> Total Paralysis	<input type="checkbox"/> Other (please explain) _____

I AGREE THAT MY NAME BE ADDED TO THE SPECIAL NEEDS SHELTER LIST. I GIVE SEMINOLE COUNTY EMERGENCY MANAGEMENT AUTHORITY TO SHARE THIS INFORMATION WITH OTHER LOCAL SUPPORT AGENCIES IN THE EVENT OF AN EMERGENCY EVACUATION. I UNDERSTAND THAT BY SIGNING THIS FORM, I GRANT EMERGENCY RESPONDERS PERMISSION TO ENTER MY HOME AT THE TIME OF AN EMERGENCY.

SIGNATURE: _____ Date: _____
(Special Needs Client or their Authorized Agent)

REVIEWED BY: Health Department: _____ Date: _____
Emergency Management: _____ Date: _____